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Illinois Primary Care Case Management Program
Expanded Testimony for the Illinois Health Reform Implementation Task Force
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My name is Doctor Margaret Kirkegaard and I am a board certified family physician and the Medical Director of Illinois Health Connect.

In 2006, the Illinois Department of Healthcare and Family Services (HFS) implemented a Primary Care Case Management Program founded on the Medical Home concept. The program is called Illinois Health Connect and it is administered by Automated Health Systems.

While there are varying definitions of the "Medical Home", all definitions agree that the concept refers to a primary health care team, delivering accessible, continuous, compassionate, coordinated and culturally competent care.

After four years, there are 1.8 million clients enrolled in Illinois Health Connect and over 5,700 participating medical homes which include primary care physicians, federally qualified health centers, rural health centers, nurse practitioners, and other qualified providers.

I would like to offer a summary of the progress and successes of the Illinois Health Connect program to date. I plan to offer testimony from three viewpoints: the patient's view, the provider's view, the view of the Illinois citizens.

The Illinois Health Connect call center receives approximately 80,000 calls per month and assists clients in enrolling in the "best fit" medical home. A mother can call and ask for a pediatrician who speaks Polish and is on the bus route and we can assist her in getting connected to that medical home. The ability to assist in a "best fit" contributes significantly to patient satisfaction and, ultimately, to health outcomes achieved in the medical home.

Over the past four years, Illinois Health Connect has worked assiduously to educate patients about the concept of the medical home and the importance of continuity of care. In a recent survey of randomly selected Illinois families conducted by the University of Illinois at Chicago, respondents with children insured through HFS were significantly more likely to report their children had a "medical home" than were caregivers of children enrolled in private health insurance plans and uninsured children. Fewer respondents with children enrolled in All Kids were unclear about the meaning of "medical home" compared to respondents with privately insured children. The study also found that HFS enrolled clients had equal access to well child visits through their medical home as privately insured children.

Illinois Health Connect has performed an annual client satisfaction survey in 2009 and 2010. In the 2010 survey, 99% of urban respondents and 91% of rural respondents indicated that they knew their medical home. In both years and for both rural and urban clients, between at least 97% of respondents were satisfied or highly satisfied with their medical home and 95% were satisfied or highly satisfied with the administration of Illinois Health Connect.

From the provider view point, Illinois Health Connect has created a robust network while at the same time allowing providers high control over their participation. When a provider enrolls with IHC as a medical home, the provider indicates the maximum number of patients that the medical home can care for and other parameters that would determine which patients would be best suited to that medical home such as the age of the patient. Physicians value this high degree of control and it has contributed to the successful development of the IHC PCP network. We currently have 5,700 medical homes enrolled with a capacity for 5.4 million clients or three times the current client enrollment.

Illinois Health Connect also performs an annual provider satisfaction survey. In the most recent survey, over 92% of respondents agreed or strongly agreed that Illinois Health Connect is beneficial to patients and nearly 85% of respondents were satisfied with the administration of the IHC program.

Illinois Health Connect has created a Bonus Payment Program for High Performance that allows providers to be compensated for achieving certain benchmarks on nationally established primary care measures such as rates of mammography and developmental screening. In 2009, $2.8 million dollars were dispersed to IHC PCPs; and in 2010, $3.2 million dollars were dispersed. Some providers received bonuses up to $40, 000.

Illinois Health Connect keeps providers connected to HFS and informed of any changes in the administration of the program. IHC performs academic detailing to providers of over 350 visits per week. IHC also employs a team of quality assurance nurses who are able to assist practices with clinical quality improvement. I want to note that none of these activities include utilization management which is often perceived by physicians as unnecessary second-guessing of clinical judgment and an intrusion on the doctor-patient relationship.

This communication infrastructure also serves to give participating providers a voice in policy development. There are five advisory subcommittees that meet 2 to 4 times per year with open participation which creates nearly 20 opportunities to provide input from the front lines of clinical care.

Let's take a look at IHC from the vantage point of the Illinois citizen. What do we, as a state, want from our tax-sponsored health care? We want to know that costs are contained and that the healthcare provided is effective. Analysis indicates that Illinois Health Connect has achieved a reduction in both Emergency Department (ED) utilization and hospitalizations. This is a central tenet of the medical home model, that if care can be coordinated and provided through the medical home, fewer patients will get out of control and require expensive hospitalizations and emergency care. If patients have a medical home and understand the medical home concept, they will be less likely to use the ED unnecessarily.

Cost savings attributed to IHC were estimated at $80 million in FY 2008 and $120 million in FY 2009. However, saving money would not be ethical or desired if it came at the expense of providing less care. Illinois Health Connect tracks population-based health outcomes and I will share a few examples. The rate of developmental screening to identify kids who are at risk for life-long disabilities has increased over 10%. Rates of adolescent check-ups have increased nearly 4%. Ensuring that kids get needed medical care and grow up without disabilities is why we provide healthcare. Healthier kids and families mean better school performance, a more productive workforce and healthier communities.

During the debate about health reform, there has been a great deal of discussion about integrated care and Accountable Care Organizations. I want to reference an article published in the December 10th, 2009 edition of New England Journal of Medicine comparing the Patient-Centered Medical Home and Accountable Care Organizations:

"These two approaches are synergistic models of delivery-system reform that, together, promise to redirect the U.S. delivery system toward reduced cost growth and improved quality. ACOs will require a strong primary care core to succeed and, in turn, can provide essential delivery-system infrastructure beyond the primary care practice to ensure the full realization of the PCMH model."

In summary, Illinois Health Connect has demonstrated cost savings, high patient and provider satisfaction and improved care. Primary Care Case Management creates a successful infrastructure for implementing a population-based Medical Home Model. It is critical that any future health reforms in Illinois, especially attempts to create vertical integration, incorporate the Medical Home Model and Primary Care Case Management as the cornerstone. Thank you.